# 24 Month Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

**HISTORY**:

**Temp:** _____
**Pulse:** _____
**Resp:** _____

**Parental Comments/Concerns:**

**Dental Screen:** Routine: _____ Urgent: _____ Parent advised: _____ Brushing teeth? Yes _____ No _____

**Nutritional Screen:** Adequate _____ Inadequate _____ Supplements: _____

**Hearing Screen:** Within normal limits (ABR, OAE): Yes _____ No _____ **Speech:** Within normal limits? Yes _____ No _____

**Developmental Screen:** Age Appropriate? (e.g., 20 word vocabulary, kicks ball, stacks 5 or 6 blocks) Yes _____ No _____

If suspicious, specific objective testing performed _____

**Behavioral Screen:** Age appropriate? (parental interview) Yes _____ No _____

**PHYSICAL EXAM**

| Are the following normal? | Yes | No | Describe abnormal findings: |
|---|---|---|---|
| 1. Skin/Hair/Nails | | | |
| 2. Ear/Hearing | | | |
| 3. Eyes/Vision (red reflex) | | | |
| 4. Mouth/Throat/Teeth | | | |
| 5. Nose/Head/Neck | | | |
| 6. Heart | | | |
| 7. Lungs | | | |
| 8. Abdomen | | | |
| 9. Genitourinary | | | |
| 10. Extremities | | | |
| 11. Spine (scoliosis) | | | |
| 12. Neurological | | | |

**LABS ORDERED:**

Tuberculin Test
Yes _____ No _____
**(perform if at risk)**

**SCREENINGS:**

Blood Lead Test
Yes _____ No _____
**(perform at 24 mo of age)**

**ADDITIONAL LABS ORDERED:**

Hgb/Hct Yes _____ No _____
Urinalysis Yes _____ No _____
Other:

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:** **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** _____ **Deferred?** _____

**Given today?** **Hep B** _____ **Varicella** _____ **Hep A** _____ **PCV** _____ **Influenza** _____ **Other** _____

**ANTICIPATORY GUIDANCE**

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat
- Nutrition/exercise
- Sun safety
- Dental caries prevention
- Toilet training
- Read to child
- Family involvement
- Interaction with parents
- Next appt./transportation?

**REFERRALS:**

**Behavioral** _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

**WIC** _____ **Specialty** _____ **Developmental** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

Revised January 1, 2004